Hamilton Psychological Services

Patient Information

Patient Name _____ Birth date_____/_____/_____

FOR MINORS, PARENT/GUARDIAN INFO BELOW

Name _____

Relationship _____

Address _____

City _____ State _____ Zip _____

Phone _____

Email _____

Gender M F Status: S M D W

PCP: _____

Phone Number_____ Fax_____

Insurance Information

Primary Insurance _____

Policy ID #_____ Group # _____

Insurance phone #_____ Effective date _____

Policy holder _____ Birth date: ___/____/____

Relation to patient _____

Secondary Insurance_____

Policy ID #_____ Group # _____

Insurance phone #_____ Effective date _____

Policy holder _____ Birth date: ___/____/____

Relation to patient _____

Patient Financials (for office use only)

Copay/Coinsurance _____

Deductible

Ind _____ Family_____ Amount met _____

Out of pocket

Max_____ Amount met _____

Allowed Amounts

90791 _____ 90834 _____ 90837_____ 90846_____

90847_____ 96101 _____ 96118 _____

90876(Neurofeedback)_____

Authorization Information (if Applicable)

Authorization # _____

Number of Visits _____ Dates _____ To_____

Is a separate authorization required for testing? Y N

Representative spoken with _____

Call Reference # _____